Patient Safety Program Approach – HCQCC, May 2012

Goal

By January 2014 all settings in which patient care is delivered shall establish a Patient Safety Program.

Outline of Voluntary Program Elements (Defined in the resource guide):

- Leadership in the setting
- Identify a patient safety point of contact at the site (not necessary to hire for this position)
- Continual process improvement
- Regular review of events and concerns (monthly or quarterly staff meetings):
    - Analysis of event(s) that occurred and plans for corrective action(s)
    - Identify risks or potential problems before they occur and take correct action(s)
    - Review risks and possible risks in transitions of care
- Input from patients and families

Implementation

- Share with state agencies that interact with health care organizations
- Partner with professional organizations and associations who will work with their members, providing education, sharing best practices, and assessing implementation
- Provide as a general resource this brief guide to the professional organizations and associations to share with their members. Encourage professional organizations and associations to add strategies and resources for their specific health care setting.
- Develop a reporting survey with professional organizations and associations that will be given to each member for voluntary completion, to be shared in aggregate with the HCQCC through the professional organizations and associations at the end of the pilot period, and again annually. Template will include questions about the important and sustainable elements of a patients safety program

Year 1 (2012): Engagement

Year 2 (2013): Progress in settings with feedback from professional organizations and associations to the HCQCC and survey development

Year 3 (2014): Data collection and Public Engagement

- Data collection by professional organizations and associations of their members' patient safety initiatives to be shared in aggregate to the HCQCC initially. Future reports from each association will be considered for public sharing.
- Outreach to the public to explain that healthcare settings have patient safety programs. Ask for the patient safety coordinator at your facility if you have suggestions or want more information

Timeline: 2011 - 2013

Month	Task
Jan 2011 – April 2012	• Develop initial guide " Guideline for Patient Safety Program in all Healthcare Settings" • Develop rollout process • Define list of state agencies for outreach • Define full list of professional organizations and associations
May 16 2012	• Quality and Safety Committee complete draft document, present for HCQCC approval • Present rollout process for HCQCC comment
May 2012 – December 2012	• Post document on HCQCC website • Quality and Safety Committee engage Professional Organizations and Associations through a series of small meetings; get input for strategy • Develop cover letter for EOHHS Secretary; with professional associations, develop draft cover letter language for endorsement • Quality and Safety Committee collects comments, additional resources, providers update to HCQCC • Professional Organizations and Associations begin outreach to engage their memberships
January 2013- May 2013	• Professional organizations continue to offer education, feedback and tools to their members on best practices and lessons learned • Professional organizations and Quality and Safety Committee, with HCQCC, develop a survey tool to be used in fall of 2013
June 2013- December 2013	• Quality and Safety Committee outreach to professional associations to conduct survey

2014 and Beyond

Month	Task
January 2014 – March 2014	• Professional organizations report back best practices and lessons learned in aggregate to Committee. • Results reviewed by professional organizations and committee and consideration be given to having the HCQCC post progress on its administrative website
January 2014 - December 2014	• Professional organizations continue to offer education, feedback and tools to their members on best practices and lessons learned • Outreach to patients/consumers about patient safety programs in all settings • Data collection using surveys in fall 2014
January 2015	• Reporting in aggregate by the Professional organizations and associations to the HCQCC on progress in settings based on Year 1 of the survey data
March 2015	• Review of results and consideration by the committee and professional organizations regarding HCQCC posting progress on its administrative website

Patient Safety Program Process